

MODERNIZING MEDICAID PROVIDER QUESTIONS AND ANSWERS

Questions	Answers
1. What is a “rolling year”?	<p>A rolling year starts on the day a service is received and ends 360 days later.</p> <ul style="list-style-type: none"> • In the Medicaid Basic and Enhanced Plans, adult wellness exams are limited to once per rolling year. • In the Basic Plan, inpatient mental health services are limited to 10 days per rolling year.
2. What is a “calendar year”?	<p>A calendar year begins January 1 and ends on December 31. In the new Medicaid Basic Plan, mental health services are limited to 26 services per calendar year.</p>
3. H0031 is limited to 24 units per year—is the “year” from the date of their Medicaid determination, a fiscal year from July 1 st to July 1 st , or a rolling year/twelve months from the last time that code was billed?	<p>The year is “calendar” unless otherwise stated.</p>
4. H0031 is not only the code used for Comprehensive Assessment, it is the code used in Service Coordination for assessing participants—since it is limited to 24 units per participant how can a participant obtain an assessment for each	<p>Although code H0031 is used for both the Comprehensive Assessment and the Service Coordination Assessment the code is “translated” in the system based on the information provided on the claim form, specifically the provider type and specialty; therefore, a participant has the benefit of 24 units of a Comprehensive Assessment and 24 units of a Service Coordination Assessment.</p>

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of these services?	
5. How are new participants assigned to Basic or Enhanced Plans?	<p>New Medicaid participants are assigned to Basic or Enhanced Plans based on their health needs. At application participants have the opportunity to inform the Department of established health needs that help in this determination.</p> <p>Following enrollment into Medicaid Basic Plan a participant may obtain a referral from his PCP for mental health services. This referral may be for Mental Health Clinic services that are available in the Basic Plan or the PCP may have determined that the participant needs Enhanced Plan services so he'll make the referral for a Comprehensive Assessment so that the eligibility for Enhanced Plan services can be determined.</p>
6. How are existing participants assigned to Basic or Enhanced Plans?	<p>The review of an existing participant's need for Basic versus Enhanced Plan services coincides with the participant's Medicaid renewal date. Renewal generally occurs annually. Prior to the renewal, the participant's utilization of services will be reviewed. If the participant has used PSR services in the past 90 days or if the participant has had an inpatient psychiatric hospitalization in the previous 12 months the participant will be placed in the Enhanced Plan by the Department. In this case, the participant's PSR provider does not need to determine eligibility for Enhanced Plan placement and does not need to submit form H0002. The PSR provider should continue on the existing schedule of performing the annual comprehensive assessment and treatment plan development and reviews.</p> <p>If the participant is a high utilizer of mental health services and/or receives partial care but is not a utilizer of PSR and has not had a comprehensive assessment in the previous 12 months the participant will receive a letter from the Department encouraging him to obtain a Comprehensive Assessment so that it can be determined if he qualifies for Enhanced Plan services. These participants will be requesting Comprehensive Assessments from their providers.</p>
7. Should providers go ahead and assess everyone now to get them qualified for services so that participants don't run out of services when they need them?	<p>Assessments must be driven by medical necessity and must not be completed in anticipation of reducing administrative tasks of a future date.</p> <p>Providers who encounter a participant who they suspect may meet the criteria for enhanced plan services do not need to wait until the participant receives a referral letter to complete a Comprehensive Assessment. However, Providers should always check eligibility before providing services. Refer to IR MA06-18 for additional information about checking eligibility.</p>

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<p>8. What if months prior to his annual Medicaid renewal date a participant suddenly decompensates and needs PSR or after receiving some clinic services it is established that he could benefit from clinic services that are only available in the Enhanced Plan?</p>	<p>At any point in the calendar year a provider may make a clinical decision based on medical necessity to assess a participant to determine the participant's eligibility for Enhanced Plan Services. If the participant is enrolled in the Basic Plan at the time of the assessment, and the provider concludes the participant meets the criteria for SED or SPMI based on the Comprehensive Assessment the provider should then submit an H002 form to the Department's Family Medicaid unit.</p>
<p>9. What if the participant did not qualify for Enhanced Plan services at the time of the assessment, but there are significant changes in his condition six months later?</p>	<p>If a second assessment is necessary it can be provided if the participant has benefits remaining and there is medical necessity. Both Clinic and PSR providers can provide a 2nd Comprehensive Assessment. It does not need to be PA'd.</p>
<p>10. What if the Comprehensive Assessment is found to be of poor quality, does not meet the standard of rule for what's required to be included and a subsequent treatment provider feels it is insufficient to use to develop a treatment plan?</p>	<p>It is the same scenario under Medicaid Modernization as it was prior to Modernization when a participant uses up his benefit of a certain service but the provider determines the participant still needs more of that service. Children have the possibility of obtaining services beyond established limitations through EPSDT eligibility.</p> <p>Providers should assess participants to the extent they determine clinically necessary and a benefit is available. There are other diagnostic and evaluation services available: psychiatric diagnostic interview, psychological testing, social history—even collateral contact can provide valuable information that can help in the development of a treatment plan when other data is lacking.</p> <p>A participant must only have a 2nd Comprehensive Assessment performed for reasons of medical necessity, not due to questions of quality. As announced in Information Release MA06-28, incomplete assessments are subject to recoupment.</p>

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11. What should a provider do when they can't get a participant's medical records from his previous mental health provider?	<p>When providers have the participant's permission to obtain his medical records from his previous mental health provider but for some reason the present provider cannot access the records, either because the participant can't remember the name of the first provider or perhaps the first provider is not cooperating, the provider seeking the records should contact the Medicaid central office for assistance.</p>
12. In anticipation that a participant will need continued services for the following year, should providers continue to include the hours needed for the annual re-assessment on the plan that is submitted to the MHA for obtaining the PA of the PSR services? Or, can those be omitted from now on?	<p>No, providers do not need to request hours of service that are not required to be PA'd.</p>
13. Will clinic providers have to become CAFAS certified to be able to complete the comprehensive assessment and make the determination that a child meets SED criteria?	<p>Yes. As announced in Information Release MA06-28, all providers who intend to bill Medicaid for performing the comprehensive assessment (code H0031) must comply with requirements presently described in IDAPA 16.03.09.453.01. New rules being published August 2, 2006 will describe the same standards in IDAPA 16.03.10.112.</p>
14. How do these changes affect the participants who are being discharged from	<p>As a result of psychiatric hospitalization a participant is automatically placed in Medicaid Enhanced Plan by the Department. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population are considered</p>

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psychiatric hospitals?	<p>immediately eligible for PSR services for a period of 120 days. A PSR provider can develop a treatment plan for the participant who meets the diagnostic criteria for PSR without a PA for the allowed two hours of H0032. The treatment plan must be completed and submitted to the Mental Health Authority for prior authorization within ten (10) calendar days of the date of hospital discharge. As per rule, the services may be provided for up to 120 days following discharge from the hospital. A Comprehensive Assessment would then need to be done to establish PSR eligibility to keep the person in PSR beyond the 120 days (according to existing rule) but the provider doesn't have to submit form H0002 because the participant is already in the Enhanced Plan. The provider will submit the Comprehensive Assessment and Treatment Plan to the Mental Health Authority in order to get approval and be PA'd for services beyond the 120 days.</p> <p>A Mental Health Clinic may serve a participant with Enhanced Plan services following a psychiatric hospitalization after a Comprehensive Assessment has been completed that has established the participant meets the criteria for SED or SPMI. The Mental Health clinic provider does not need to submit form H0002 because the participant is already in the Enhanced plan.</p>
15. What services does the 26 service limitation apply to?	Psychotherapy and psychopharmacology. The 12 hour limitation of diagnosis and evaluation also comes out of the 26 hour limitation. The other services available in the mental health clinic such as nursing services and collateral contact are not affected by the 26 service limitation.
16. In the Enhanced Plan can a participant get 45 hours of psychotherapy?	yes
17. How do I know if a participant is on the Basic or Enhanced Plan and whether or not he has benefits of a certain service remaining?	When participants present for services at provider clinics/agencies the provider should verify the participants' Medicaid eligibility per usual practice, through MAVIS, POS device or PES. The eligibility response will indicate "Medicaid with benefits restricted to Medicaid Basic Plan services" for Basic plan and "Medicaid" for Enhanced Plan. The provider should also indicate what specific service he intends to provide on that date. The system will supply the information back to the provider about whether or not the participant has sufficient benefits remaining of that particular service.
18. As a provider, how can I	There is no need for a provider to determine when a participant's renewal will take place. To

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determine when a participant's renewal date is?	ensure claims are not denied due to eligibility or benefit plan issues, verify participants' eligibility and benefit plan on the actual date of service. If enhanced services are required by a participant enrolled in the Basic Plan, follow the assessment process outlined in IR MA06-27.
19. How can a participant only have one treatment plan if he has a Mental Health Clinic provider and a PSR provider?	To maximally benefit from the current structure that allows for multiple providers, participants must have only one treatment plan between all outpatient mental health providers of clinic and psr services. Operating within the constraints that exist, clinic providers must be responsible for goals and objectives appropriate to the clinic interventions and the psr providers must be responsible for the goals and objectives appropriate to the PSR interventions. Figuratively, a participant's treatment plan must be viewed as one document, a prescription of care that contains elements of intervention designed for his best opportunity for recovery, however the participant (or guardian) has defined recovery. At this time there is no requirement for a uniform format, font, or style between the two provider types.
20. Does every Mental Health Clinic record need to contain both a Comprehensive Assessment and a Social History and how can a provider keep from keeping these two from being duplicative as required by IR MA06-28?	Every Mental Health Clinic participant medical record must contain a Social History (code T1028), also referred to as an Intake Assessment, as required by IDAPA 16.03.09.713.01. Regulations at IDAPA 16.03.09.713.02 require that all treatment be based on an individualized assessment of the participant's needs, including a current mental status examination; however, the type of assessment is not specified. This requirement may be met in the Social History, or through any of the other diagnostic & evaluation procedures if they are medically necessary. Comprehensive Assessments must not be completed by Mental Health Clinic providers except for reasons of medical necessity in determining criteria for participants obtaining Enhanced Plan services. The difference between Social Histories and Comprehensive Assessments is an emphasis on the intake function of the Social History versus the in-depth focus on functional behavior in the Comprehensive Assessment.
21. How do we line up the annual dates for the treatment plans when the participant's Clinic plan is due one month and his PSR plan is not due for several months more?	For participants who are presently receiving PSR the annual date for the comprehensive assessment update and treatment plan is already established and the Clinic needs to get in sync with that date. Since July 1 st when Modernization was initiated if the Clinic annual date is due and the PSR date will not be due for a few months the Clinic should devise a plan to cover the time period covering the interim until the PSR annual comprehensive assessment and treatment plan is completed at the next PSR due date. At this point it would be a good

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	<p>idea for the Clinic to alert the PSR provider that the Clinic provider exists and will need to be coordinated with at the point of the annual PSR treatment plan update. It may even be helpful for the Clinic provider to obtain a copy of the existing PSR treatment plan to begin getting an idea of what the PSR interventions have been for the participant. At the time of the annual PSR due date both agencies should get in sync with goals and objectives for the participant via sharing a copy of the comprehensive assessment. The annual PSR date then becomes the annual Clinic date as well.</p> <p>If the PSR plan comes due before the Clinic plan is due both of the plans must be coordinated on the schedule of the PSR due date and in such a case the Clinic plan would be updated sooner than it is due this year and would now have a new annual renewal date.</p> <p>When it is one agency providing both services it is much simpler: the same principle applies—the PSR annual renewal date remains the same and the Clinic due date needs to get in sync with it. The provider must develop an interim Clinic plan until the PSR annual date arrives and both services can be coordinated onto the one plan resulting in one annual date.</p>
<p>22. Where can I get more information about the changes?</p>	<p>All Information Releases that address Medicaid Modernization topics and other related information can be found at: http://www.Modernizemedicaid.idaho.gov</p>
<p>23. Initially information was given that participants will have only one Comprehensive Assessment annually and providers should bill it in on one claim form. If a provider doesn't use the whole 6 hours of the Comprehensive Assessment benefit the first time he assesses a participant or at the annual renewal date can he use the</p>	<p>This is an update to information recently provided at the September 5th Medicaid Modernization Training for Mental Health Providers. While the benefit remains the same, participants are limited in the number of Comprehensive Assessments they may obtain based on medical necessity. Providers should assess participants according to medical necessity and the participant's remaining benefits. The system will allow providers to make multiple claims in increments as small as 1 15-minute unit. Documentation in the medical record should match each claim made.</p>

Questions	Answers
remaining units later in the year for the participant if the participant needs an update?	

Please submit questions for which no answer is provided above to: millerd1@idhw.state.id.us

We will develop answers to new questions as quickly as possible.